



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

STONEGATE SURGERY CENTER LP

MFDR Tracking Number

M4-16-1365-01

MFDR Date Received

January 21, 2016

Respondent Name

HANOVER AMERICAN INS CO

Carrier's Austin Representative

Box Number 01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are requesting a 'Reconsideration' for the patient and date of service we have listed above. The original claim did not pay correctly as line 3 and 4 were denied because 'the benefit for this service is included in the payment for another service' [sic]. We billed 24685 to allow at 153% of Medicare fee schedule, which means we are expecting reimbursement for the implant C1713 and L8699 per TDI guidelines. The reimbursement for these codes are 23412 at 3464.31, C1713 at \$1760.000 and L8699 at \$550.00. Since we already received a payment of \$6392.71 we are expecting an additional payment of \$1293.52. Attached this medical documentation to support this claim."

Amount in Dispute: \$2,310.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Stonegate Surgery Center LP is in-network member of the CorVel Texas CorCare Certified Network effective 3/27/2009 and reimbursement in the amount of \$4,480.79 for outpatient services was based on a negotiated network contract rate."

Response Submitted by: CORVEL

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
June 05, 2015	CPT Codes C1713 and L8699	\$2,310.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305, sets out the procedures for resolving medical disputes.
2. 28 Texas Insurance Code Chapter 1305 applicable to Health Care Certified Networks.
3. 28 Texas Administrative Code §10.120 through 10.122 address the submission of a complaint by a health care provider to the Health Care Network.

Issues

1. Did the in-network healthcare provider render services to an in-network injured employee?
2. Is the requestor eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.305?
3. What may be the appropriate administrative remedy to address fee matters related to health care certified networks?

Findings

1. The requestor billed for CPT Codes C1713 and L8699 rendered on June 05, 2015 to an injured employee enrolled in a certified healthcare network. The requestor seeks a decision from the Division's medical fee dispute resolution (MFDR) section. The Division finds that the disputed services were rendered by an in-network healthcare provider to an in-network injured employee.
2. The authority for MFDR to resolve matters involving employees enrolled in a certified health care network is conditional. 28 Texas Administrative Code §133.305 (a) (4) defines a medical fee dispute as "A dispute that involves an amount of payment for **non-network** health care rendered to an injured employee that has been determined to be medically necessary and appropriate for treatment of that injured employee's compensable injury. The dispute is resolved by the Division pursuant to Division rules, including §133.307 of this title (relating to MDR of Fee Disputes." The Division defines non-network health care in paragraph (a) (6) of the same rule as "Health care not delivered or arranged by a certified workers' compensation health care network as defined in Insurance Code Chapter 1305 and related rules ..." That is, the Divisions medical fee dispute resolution section, may address disputes involving health care provided to an injured employee enrolled in an HCN, only if the out-of-network health care provider was authorized by the certified network to do so.

28 Texas Administrative Code §133.305 (a) (4) defines a medical fee dispute as "A dispute that involves an amount of payment for **non-network** health care rendered to an injured employee that has been determined to be medically necessary and appropriate for treatment of that injured employee's compensable injury. The dispute is resolved by the division pursuant to division rules, including §133.307 of this title (relating to MDR of Fee Disputes." Non-network health care is defined in Section (a) (6) of the same rule as "Health care not delivered or arranged by a certified workers' compensation health care network as defined in Insurance Code Chapter 1305 and related rules ..."

3. The TDI rules at 28 Texas Administrative Code §§10.120 through 10.122 address the submission of a complaint by a health care provider to the Health Care Network. The Division finds that the disputed services rendered by an in-network healthcare facility to an in-network injured employee may be filed to the Texas Department of Insurance's (TDI) Complaint Resolution Process, if the health care provider or facility is dissatisfied with the outcome of the network complaint process. The complaint process outlined in Texas Insurance Code Subchapter I, §1305.401 - §1305.405 may be the appropriate administrative remedy to address fee matters related to health care certified networks.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution. This finding is based upon a review of all the evidence presented by the parties in this dispute. Even though not all the evidence was discussed, it was considered. The Division finds that this dispute is not eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	2/11/2016 _____ Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your

receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).